

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 20 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-01676 REG. NO.					
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR A	
1. DECEASED NAME FIRST MIDDLE LAST <b>Herbert Harvey Bastain</b>				<b>January 14, 1979</b>				<b>3:40 M</b>	
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 16, 1917</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>61</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Charles</b> MD.			
10. CITY OR TOWN OF DEATH <b>La Plata</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Physicians Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Transportation</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt.</b>	
13a. STATE <b>Md.</b>				13b. COUNTY <b>Charles</b>		13c. CITY OR TOWN <b>Nanjemoy</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Samuel Bastain</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Elizabeth Murphy</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>WW11 213-16-2514</b>		17. INFORMANT ADDRESS <b>Belle Bastain same as # 13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>1629</b> IMMEDIATE CAUSE (a) <b>Respiratory failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma lungs</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>one year</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 days</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>1-9-1979</b> , to <b>1-14-1979</b> , that (I) (we) last saw the deceased alive on <b>1-13-1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>h. S. Nett</b>				DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>1/14/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Girija S. Rath, MD</b>				22e. ADDRESS <b>WALDORF, Md. 20601</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>1-16-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Old Durham Ch. Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Ironsides Chas. Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Wint Funeral Home</b>				ADDRESS <b>Waldorf Md.</b>		25a. DATE RECEIVED BY REGISTRAR <b>JAN 18 1979</b>			
25b. REGISTRAR'S SIGNATURE <b>Mary McCready</b>									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01677 REG. NO.	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST John Lewis BEAN						2a. DATE OF DEATH MONTH DAY YEAR JAN 7 1979		2b. HOUR 4:53 P M	
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR 4 10 24		6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD.					
10. CITY OR TOWN OF DEATH La Plata		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farming			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Chapel Point Road			
13a. STATE Maryland		13b. COUNTY Charles		13c. CITY OR TOWN Port Tobacco							
14. FATHER'S NAME FIRST MIDDLE LAST James Francis Bean				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Wills							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577-38-3598		17. INFORMANT ADDRESS Mr. James F. Bean 105 Woodland Rd. 20640 Indian Head, MD.							
18. CAUSE OF DEATH (Enter only one cause per line form (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5939 Respiratory Collapse. DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac arrest. DUE TO, OR AS A CONSEQUENCE OF (c) End Stage renal disease.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3m 53min 3months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Patient been on hemodialysis											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 4 Oct 1978, to 7 Jan 1979, that (I) (we) last saw the deceased alive on 7 Jan 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (do not) view the body after death.											
22b. SIGNATURE Arthur O. Woody MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 8 Jan 79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARTHUR O. WOODY.				22e. ADDRESS Box 430 LA PLATA. MD. 20646.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/10/79		23c. NAME OF CEMETERY OR CREMATORY St. Ignatius Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Chapel Point Charles Maryland					
24. FUNERAL DIRECTOR'S NAME Richard Funeral Home, Inc.				25a. DATE REC'D. BY REGISTRAR JAN 12 1979		25b. REGISTRAR'S SIGNATURE Dorothy McCready					

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79-01677

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-01678 REG. NO.			
1. FOR STATE REGISTRAR							
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Harry Benjamin Bowie</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>1-5-79</i>			
3 SEX <i>male</i>		4 RACE <i>White</i>		5 DATE OF BIRTH MONTH DAY YEAR <i>11-4-01</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>77</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Charles</i> MD	
10 CITY OR TOWN OF DEATH <i>N. Riverside</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Box 260 Nanjemoy, Maryland</i>		12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) <i>Welder</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>M.S. NOS</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <i>md.</i>				13c. CITY OR TOWN <i>Charles</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <i>Joseph Emory Bowie</i>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Edith M. Madigan</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <i>220-40-4238</i>		17 INFORMANT ADDRESS <i>Daughter - Myra Miller Bowie, MD. 20775</i>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <i>coronary artery disease</i> (c) <i>Gen. arteriosclerosis</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <i>Stroke &amp; Hydrocephalus secondary to CVA</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. If (we) (I) did not view the body after death.							
22b. SIGNATURE <i>[Signature]</i> MD.				DEGREE <i>MD.</i>		22c. DATE SIGNED <i>1-5-79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>THOMAS E. JOSEPH JR. MD</i>				22e. ADDRESS <i>Physicians Mem. Hosp, La Plata, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>1-8-1979</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Nanjemoy Baptist Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Nanjemoy Charles Maryland</i>	
24. FUNERAL HOME NAME <i>Funeral Home, Inc. La Plata, MD</i>				25a. DATE REC'D. BY REGISTRAR <i>JAN 12 1979</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

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82010-02



NAME: Clara N/M/N Bramell

DATE OF DEATH: January 29, 1979

PLACE OF DEATH: Charles County

SEE: #79-04367  
February, 1979  
Charles County





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										79-01679 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Edmond R Carrington										2a. DATE KNOWN OF DEATH XX MONTH DAY YEAR 1 8 19 79		2b. HOUR M 4:16 P.M.	
3 SEX male		4. RACE black		5. DATE OF BIRTH MONTH DAY YEAR July 14 1918		6. AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN 60 YRS.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 8 19 79		7d. HOUR P.M.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles County MD.					
10. CITY OR TOWN OF DEATH La Platta		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physician's Memorial Hospital						12a. USUAL OCCUPATION (TYPE OF WORK) (FOR MOST OF WORKING LIFE) TRANS FERE		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MARYLAND		13b. COUNTY CHARLES		13c. CITY OR TOWN PISCATAWAY		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Route 425					
14. FATHER'S NAME FIRST MIDDLE LAST Nether Carrington						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Aline Erans							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO. 225-14-6392		17. INFORMANT Mary O. Carrington				ADDRESS Piscataway, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>leg vein thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>Fracture right patella</u>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <u>Fracture right patella</u>						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR MONTH DAY YEAR 2:00 P.M. 12/18 1978		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <u>ejected backhoe operator</u>							
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <u>Refuse Center</u>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u>4900 Bates Rd-NE, Washington, DC</u>							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <u>H. S. Guard</u>				TITLE (SPECIFY) Assistant				DATE SIGNED 1/9/79					
EXAMINER'S NAME (TYPE OR PRINT) <u>Hormez R. Guard, M.D.</u>				ADDRESS <u>111 Penn Street, Balto, MD 21201</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>				23b. DATE <u>1-13-79</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. John Bapch.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Clarksville VA.</u>					
24. FUNERAL DIRECTOR NAME <u>Leon Thornton</u>				ADDRESS <u>R. Route 1-Box 115 Pomomkey, Md.</u>		25a. DATE REC'D. BY REGISTRAR <u>JAN 17 1979</u>		25b. REGISTRAR'S SIGNATURE <u>Robert McCreedy</u>					

29-01679

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01680

1. DECEASED-NAME (Type or print) <i>Lindsey Omer Cockerham</i>			2a. DATE OF DEATH Month <i>Jan</i> Day <i>14</i> Year <i>1979</i>			2b. HOUR <i>12:30 PM</i>				
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>May 28, 1909</i>		6. AGE (In years last birthday) <i>69</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <i>North Carolina</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Charles</i> Md.				
10. CITY OR TOWN OF DEATH <i>La Plata</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Rt. 2, Box 2206</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Chauffer (Ret.)</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Govt.</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>			13b. COUNTY <i>Charles</i>		13c. CITY OR TOWN <i>La Plata</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>Rt. 2, Box 2206</i>	
14. FATHER'S NAME First Middle Lost <i>Duffy Cockerham</i>			15. MOTHER'S MAIDEN NAME First Middle Lost <i>Rossie Ramey</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16b. SOCIAL SECURITY NO. <i>225-05-2963</i>		17. INFORMANT Address <i>Irene K. Cockerham Rt. 2, Box 2206, MD. 20646</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Stomach</i> <i>1519</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (1) (this hospital) attended the deceased from <i>Sept 8, 1978</i> , to <i>Jan 14, 1979</i> , that (1) (we) last saw the deceased alive on <i>Jan 12, 1979</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>1 Lucy J. Bunker</i>					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>1-14-79</i>			
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Jan. 17, 1979</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Trinity Memorial Gardens</i>		23d. LOCATION (City or Town) (County) (State) <i>Waldorf Charles Maryland</i>				
24. FUNERAL DIRECTOR ADDRESS <i>Arehart Funeral Home, Inc. La Plata, Maryland</i>					25a. REC'D BY REGISTRAR DATE <i>JAN 22 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Jeffrey McCreedy</i>			

10-01880

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		79-01681						REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		Cecil Wesley Curtis				2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR IF UNDER 24 HRS	
Male		Cau.		Feb. 12, 1903		75 YRS		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Maine		U.S.A.				Charles MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
La Plata		Physicians Memoiral Hospital				Farmer		Farm	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS	
Maryland		Charles		Waldorf				325 Barksdale Avenue	
14 FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Frank A. Curtis		Mary Flewelling							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
NO		004-12-8670		Vincent Clark same as 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic failure</u> 1519 DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastasis in liver + pancreas</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cancer of Stomach</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 22</u> , 19 <u>78</u> , to <u>Jan 2</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>Jan. 1</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
N. Bhaduri MD								1-2-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
Niren Bhaduri, M.D.		Waldorf, Maryland 20601							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		1-5-79		St. Dennis Cemetery		Ft. Fairfield, Maine			
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE RECD. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Hunt Funeral Home Waldorf, Maryland				JAN 8 1979		Anthony McCready			

18810-27

January 2, 1970

Good morning

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 25M

(VR A 15 (4) 9/74)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01682

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MYRA ALICE DRINKARD			2a. DATE OF DEATH MONTH DAY YEAR 1 6 1979		2b. HOUR 4:10 P.M.
3. SEX FEMALE	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept. 5, 1894	6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD.		
10. CITY OR TOWN OF DEATH Indian Head	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 33 Mattingly Ave.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Own Home	

13a. STATE Md.			13b. COUNTY Charles	13c. CITY OR TOWN Indian Head	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 33 Mattingly Ave.
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14. FATHER'S NAME FIRST MIDDLE LAST John H. Ennis		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice B. Fulwaller	
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16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-34-7118	17. INFORMANT ADDRESS 1036 East Pot. Ave. Indian Head, Md.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 4280 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (1) (this hospital) attended the deceased from 8-13, 1979, to 1-6, 1979, that (1) (we) lost saw the deceased alive on 1-6, 1979, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.

22b. SIGNATURE Henry L. Burke M.D.	DEGREE	22c. DATE SIGNED 1-6-79
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22d. PHYSICIAN'S NAME (TYPE OR PRINT) Henry L. Burke M.D.	22e. ADDRESS La Plata, Maryland 20646
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23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1-9-79	23c. NAME OF CEMETERY OR CREMATORY Trinity Mem. Garden	23d. LOCATION CITY OR TOWN COUNTY STATE Waldorf Charles Md.
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24. FUNERAL DIRECTOR NAME Huntt Funeral Home	25a. DATE RECEIVED BY REGISTRAR JAN 12 1979	25b. REGISTRAR'S SIGNATURE [Signature]
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79-01885

CHIEF

DOCK COTTON



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-01683 REG. NO.					
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST David Algernon Farr				January 1, 1979				2:35A <sub>M</sub>	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR April 8, 1891		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD.			
10. CITY OR TOWN OF DEATH La Plata		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Passenger Conduct		12b. KIND OF BUSINESS OR INDUSTRY Penn. R.R.	
13a. STATE Maryland				13b. COUNTY Charles		13c. CITY OR TOWN Wayside		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Gregory Farr				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Irene Davis					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 717-07-8020		17. INFORMANT ADDRESS Mrs. Margaret Farr Rt. 1, Box 154 Md. 20664 Newburg,					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 436- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF gangrene of amputated leg. 1 week. pneumonia 1 week.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): stroke 6 months ago.									
19a. DATE OF OPERATION <del>12-31-78</del>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED gangrene of foot				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12-31-78 to 1-1-79, that (I) (we) lost saw the deceased alive on 12-31-78, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Frederick M. Johnson				22c. DATE SIGNED 1-1-79				22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frederick M. Johnson, M.D.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-4-1979		23c. NAME OF CEMETERY OR CREMATORY Holy Ghost Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Issue Charles Maryland			
24. FUNERAL DIRECTOR NAME The Church Funeral Home, Inc. 2111 N. Maryland Rd.				25a. DATE REC'D. BY REGISTRAR JAN 4 1979		25b. REGISTRAR'S SIGNATURE Anthony McCready			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-01684 REG. NO.	
1. FOR STATE REGISTRAR					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Catherine E. Hawkins			2a. DATE OF DEATH MONTH DAY YEAR January 16 1979		2b. HOUR P. 8:55 AM
3. SEX female	4. RACE Negro	5. DATE OF BIRTH MONTH DAY YEAR 5/4/1926	6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) 99	7b. CITIZEN OF WHAT COUNTRY? ✓	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Charles Co. MD.		
10. CITY OR TOWN OF DEATH LaPlata	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PHY. MEM. HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Charles	13c. CITY OR TOWN Waldorf	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST William E. Hawkins			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah E. Winters		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-16-1747	17. INFORMANT ADDRESS Gladys Stewart Rt. 1 - Box 258 Horsehead Rd. Brandywine		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 2500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) DIBETES, PRESSURES 200/120 INFECTION (c) PROBABLE SEPSIS, HYPERTENSION DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1976, 19, to 1979, 12/9/1979, that (I) (we) lost saw the deceased alive on 12/9/1979 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Dr. N. Ramakrishna		DEGREE		22c. DATE SIGNED 1/17/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. N. Ramakrishna		22e. ADDRESS Chas. Prof. Bldg. Waldorf, Md. 20601			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/20/79		23c. NAME OF CEMETERY OR CREMATORY St. Peters Ch. Cm.	
23d. LOCATION CITY OR TOWN COUNTY STATE Waldorf Charles Co. Md.		23e. DATE REC'D. BY REGISTRAR JAN 24 1979		23f. REGISTRAR'S SIGNATURE Rickey McCreedy	
24. FUNERAL DIRECTOR NAME Adams Funeral Home		ADDRESS Crownsville Md.			

BP

52-01884

PHYS. MEN. HOSPITAL

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131-134

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01685

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>RAYMOND CORMILUS HILL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JAN 23, 1979</b>			2b. HOUR <b>11:00</b> P M				
3. SEX <b>Male</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>01 28 94</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84 85</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>CHARLES</b> MD.				
10. CITY OR TOWN OF DEATH <b>LAPLATA.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PHYSICIANS MEMORIAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>FARMER (RETIRED)</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Ches.</b>		13c. CITY OR TOWN <b>Newburg</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Box 131</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>GEORGE Hill</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CAROLINA MIDDLETON</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				
16b. SOCIAL SECURITY NO. <b>212-16-3190A</b>			17. INFORMANT <b>MARIE JENIFER Landwehr</b>			ADDRESS <b>2209 Virginia Ave Md. 20785</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory collapse.</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Congest heart failure.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Generalized arteriosclerosis.</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 min</b> <b>5 day</b> <b>15 years.</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Diabetes &amp; gangrene both feet, Carcinoma stomach, inoperable.</b>										
19a. DATE OF OPERATION <b>19 Dec 78</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Carcinoma stomach.</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>April</b> 19 <b>50</b> , to <b>25 Jan</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>23 Jan</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Arthur O. Woody</b> MD DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED <b>23 Jan 79</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ARTHUR O. WOODY, MD</b>						22e. ADDRESS <b>Box 430 LAPLATA, MD. 20646</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>1-27-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Ghost</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>ISSUE CHARLES MD.</b>			
24. FUNERAL DIRECTOR NAME <b>LEON THORNTON</b>			ADDRESS <b>Rt 1 Box 115 Pomonkey, MD.</b>			25a. DATE REC'D. BY REGISTRAR <b>JAN 29 1979</b>		25b. REGISTRAR'S SIGNATURE		

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Important: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



28310-02



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 7/77  
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-01686 REG. NO.			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) <b>THOMAS JACKSON</b>				2a. DATE OF DEATH MONTH <b>1</b> DAY <b>3</b> YEAR <b>79</b> 2b. HOUR <b>11:40 AM</b>			
3 SEX <b>MALE</b>		4 RACE <b>NEGRO</b>		5. DATE OF BIRTH MONTH <b>JAN.</b> DAY <b>18</b> YEAR <b>1927</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>51</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>CHARLES</b> MD.	
10. CITY OR TOWN OF DEATH <b>LAPLATA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>P.M.H.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SELF-EMPLOYED</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b> 13b. CITY OR TOWN <b>CHARLES</b> 13c. CITY OR TOWN <b>NANTJEMOY</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS	
14. FATHER'S NAME FIRST <b>FRANK</b> MIDDLE <b>JACKSON</b> LAST <b>JACKSON</b>				15. MOTHER'S MAIDEN NAME FIRST <b>IRENE</b> MIDDLE <b>DORSEY</b> LAST <b>DORSEY</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>220-16-5341</b>		17. INFORMANT ADDRESS <b>B NANTJEMOY, MD. 20642</b> <b>AUDREY M. JACKSON</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>402- Hypertensive cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) _____							
MEDICAL CERTIFICATION							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 19 <b>75</b> to <b>12-20</b> 19 <b>78</b> , that (I) (we) last saw the deceased alive on <b>12-20</b> 19 <b>78</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Ignacio T. Garcia, M.D.</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1-3-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Ignacio Garcia, M.D.</b>				22e. ADDRESS <b>La Plata, Md. 20646</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1-6-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT. HOPE</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>IRONSIDES CHARLES MD.</b>	
24. FUNERAL DIRECTOR NAME <b>Leon Thornton</b>		ADDRESS <b>R. R. BOX 15 P. O. BOX 15</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 8 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

10-01886

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DHMM-16 50M 7/77  
(VR A 15 (4))

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79-01687 REG. NO.		
1. FOR STATE REGISTRAR						2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ESTELLE D. JOHNSON						1 - 17-79				1:16p M		
3. SEX FEMALE		4. RACE NEGRO		5. DATE OF BIRTH MONTH DAY YEAR AUGUST 25, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 6.5 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) 35 MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CHARLES MD.						
10. CITY OR TOWN OF DEATH LaPlata		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE 35 MARYLAND						13b. COUNTY CHARLES		13c. CITY OR TOWN INDIAN HEA		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST THOMAS DYSON						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HANNAH RAYMOND						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) 1 NO				16b. SOCIAL SECURITY NO. —		17. INFORMANT ADDRESS VERONICA C. SANDIDGE 8394 INDIAN Hl. OXON HILL, MD., Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> 436- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebrovascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>—</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>1-17-</u> 19 <u>79</u> , to <u>1-17-</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>1-17-</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>h. rath</u>						DEGREE M.D.			22c. DATE SIGNED		22d. ADDRESS Charles Professional Building, Waldorf, Md.	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) G.S. RATH, M.D.						22f. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 1-20-79		23c. NAME OF CEMETERY OR CREMATORY ST. CHARLES		23d. LOCATION CITY OR TOWN COUNTY STATE GLYNNOST CHARLES MD.				
24. FUNERAL DIRECTOR NAME LEON THORNTON THORNTON FUNERAL				ADDRESS R. Route 1 Box 115 P. MONKEY, MD.				25. DATE REC'D. BY REGISTRAR JAN 18 1979		25b. REGISTRAR'S SIGNATURE <u>P. H. Kelly</u>		

78310-27

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed 6 months after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-01688 REG. NO.			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) <b>Joe T. Johnson</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>1-4-79</b> 2b. HOUR <b>2:45 A.M.</b>			
3 SEX <b>Male</b>		4 RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 5 1904</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Charles</b> MD.	
10. CITY OR TOWN OF DEATH <b>La Plata</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Physician's Memorial Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Farmer-Produce</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Self Empl.</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>Maryland</b>		13b. COUNTY <b>Charles</b>		13c. CITY OR TOWN <b>Newburg</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Oliver Johnson</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mollie Jane Cowan</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b> (IF YES, GIVE WAR OR DATES)			
17a. SOCIAL SECURITY NO <b>577-32-0731</b>		17. INFORMANT <b>Sarah M. Johnson</b>		ADDRESS <b>Rt. 1, Box 181 MD. 20664</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of Lung</b> 1629				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF (b)							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <b>9-8</b> , 19 <b>78</b> , to <b>1-4</b> , 19 <b>79</b> , that (1) (we) lost saw the deceased alive on <b>1-3</b> , 19 <b>79</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Henry L. Burke, M.D.</b> DEGREE				22c. DATE SIGNED <b>1-4-79</b>		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Henry L. Burke, M.D.</b>				22f. ADDRESS <b>La Plata, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1-6-1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Trinity Mem. Gardens</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Waldorf Charles Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Archant Funeral Home, Inc.</b> ADDRESS <b>La Plata, MD</b>				25a. DATE REC'D BY REGISTRAR <b>JAN 12 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Henry McCreedy</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79-01689

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>YUNG SUN KIM</b>			2a. DATE OF DEATH MONTH <b>1</b> DAY <b>18</b> YEAR <b>79</b>			2b. HOUR <b>2:30</b> AM					
3. SEX <b>F</b>		4. RACE <b>Korean</b>		5. DATE OF BIRTH MONTH <b>7</b> DAY <b>21</b> YEAR <b>1898</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS HOURS <b>0</b> MIN <b>0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Korea</b>		7b. CITIZEN OF WHAT COUNTRY? <b>Per. Res. ship</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>C. Charles</b> MD.					
10. CITY OR TOWN OF DEATH <b>White Plains</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired - Prof.</b>			12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b> 13b. COUNTY <b>Calverton</b> 13c. CITY OR TOWN <b>White Plains</b>				14. INSIDE CITY LIMITS? <input checked="" type="checkbox"/>		13e. STREET ADDRESS					
14. FATHER'S NAME FIRST <b>Unknown</b> MIDDLE <b>Kim</b> LAST <b>Kim</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Sun</b> MIDDLE <b>Lee</b> LAST <b>Lee</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>219-90-728</b>		17. INFORMANT ADDRESS <b>David Hayduk Rt. 1 Box 84</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ca. Stomach</b> 1519 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Aug 78</b> , to <b>1-18 1979</b> , that (I) (we) last saw the deceased alive on <b>Aug 78</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.											
22b. SIGNATURE <b>L. H. Delaney</b> DEGREE <b>M.D.</b>						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>1-18-79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>L. H. Delaney</b>						22e. ADDRESS <b>La Plata, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>			23b. DATE <b>1-19-79</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Lee's</b>			23d. LOCATION CITY OR TOWN <b>Washington</b> COUNTY <b>D.C.</b> STATE <b>D.C.</b>		
24. FUNERAL DIRECTOR NAME <b>LEON THORNTON</b> ADDRESS <b>R.R. 1-Box 115</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 25 1979</b>			25b. REGISTRAR'S SIGNATURE <b>Henry McCreedy</b>		
NAME <b>THORNTON FUNERAL HOME</b> ADDRESS <b>Pomonkey, MD.</b>											



1a-01889

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-01690 REG. NO.					
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Pauline W. LeCrone				JAN 22 1979				9:55 AM	
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR 4-19-08		6 AGE (IN YEARS LAST BIRTHDAY) YRS 70		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Va		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH CHARLES COUNTY MD.			
10 CITY OR TOWN OF DEATH Bryans Rd. Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Box 120 F				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY AT HOME	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE Md.		13c COUNTY CHARLES		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS Box 120 F			
14 FATHER'S NAME FIRST MIDDLE LAST Sanford White				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ? UNKNOWN					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NONE		17 INFORMANT ADDRESS Husband - Donald LeCrone			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction 410- DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22 I certify that (I) (the hospital) attended the deceased from Sept 19 74, to 1-22 19 79, that (I) (we) last saw the deceased alive on 12-14 19 78, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE William Kent Furst MD				DEGREE MD				22c. DATE SIGNED 1-22-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William K. Furst, M.D.				22e ADDRESS 9401 Indian Head Highway Oxon Hill, Md.					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE 1-25-79		23c NAME OF CEMETERY OR CREMATORY TRINITY MEM. GARDENS		23d LOCATION CITY OR TOWN WALDORF		23e COUNTY STATE MD	
24 FUNERAL DIRECTOR NAME George P. Kalas Funeral Home				ADDRESS 6160 Oxon Hill Rd. Oxon Hill, Md.		25a. DATE REC'D. BY REGISTRAR JAN 26 1979		25b. REGISTRAR'S SIGNATURE [Signature]	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-01691 REG. NO.	
1. FOR STATE REGISTRAR					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Carrie Ann Mills</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>January 27, 1979</b>		2b. HOUR <b>4:10A M</b>
3 SEX <b>Female</b>	4 RACE <b>White</b> <del>Caucasian</del>	5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 8, 1897</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Charles</b> MD.		
10. CITY OR TOWN OF DEATH <b>La Plata</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Physicians Memorial Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Home maker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>at Home</b>
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Charles</b>	13c. CITY OR TOWN <b>Nanjemoy</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>Rt. 1, Box 89 D</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Connellis Andrew Mills</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Katherine Kieffer</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>215-54-7189</b>		17. INFORMANT ADDRESS <b>Nanjemoy, Md. John C. Mills, Brother-Rt. 1, Box 89D</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Collapse</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Congestive heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic Cardio-Renal disease</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 min</b> <b>3 days</b> <b>years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION <b>—</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <b>—</b>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>—</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>—</b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>20 Jan</b> 19 <b>79</b> , to <b>27 Jan</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>26 Jan</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Stonewaddy</b> MD		DEGREE <b>MD</b>		22c. DATE SIGNED <b>27 Jan 79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Arthur O. Wooddy, M.D.</b>		22e. ADDRESS <b>LA PLATA, MARYLAND 20646</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/29/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Nanjemoy Baptist Cemetery, Nanjemoy, Maryland</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>LA PLATA, MD.</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 1 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur O. Wooddy</b>	

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										79-01692 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>REBECCA Elizabeth MOORE</b>										2a. DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> DAY 1 YEAR 22 19 79										2b. HOUR M 15	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 28, 1924</b>		6. AGE (IN YEARS) (LAST BIRTHDAY) <b>54</b> YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>1 22 19 79</b> A M									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Charles County</b> MD.									
10. CITY OR TOWN OF DEATH <b>Waldorf</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Rte. Box 339 B Waldorf, Md.</b>								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Instructor</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Piano and Organ</b>					
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Charles</b>		13c. CITY OR TOWN <b>Waldorf</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Rt. #1 Box 339 B</b>											
14. FATHER'S NAME FIRST MIDDLE LAST <b>Lloyd Holsinger</b>										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Blanche Whistler</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>219-16-5579</b>		17. INFORMANT ADDRESS <b>Thomas W. Moore same as 13</b>															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>4292</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , <del>Inspection</del> <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE <i>Margarita A. Korell</i>				TITLE (SPECIFY) <b>Assistant</b>				DATE SIGNED <b>1/22/79</b>				MEDICAL EXAMINER									
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>				ADDRESS <b>111 Penn Street</b>																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>1-25-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Trinity Mem. Garden</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Waldorf, Charles, Maryland</b>											
24. FUNERAL DIRECTOR NAME <b>Huntt Funeral Home, Waldorf, Md.</b>										25a. DATE REC'D. BY REGISTRAR <b>JAN 26 1979</b>		25b. REGISTRAR'S SIGNATURE <i>Henry McBrady</i>									

78-01835



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

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(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										79-01693 REG. NO.	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) <b>WILLIAM PERRY</b>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>1 4 1979</b>		2b. HOUR <b>M</b>	
3. SEX <b>male</b>		4. RACE <b>negro</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10-15-1914</b>		6. AGE (IN YEARS) (LAST BIRTHDAY) <b>64</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>1 4 1979</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Charles County</b>			2d. HOUR <b>7a M</b>		
10. CITY OR TOWN OF DEATH <b>Marbury</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>rear of Grinder's Liquors</b>				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>RETIRED</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>MD.</b>		13b. CITY OR TOWN <b>CHARLES MARBURY</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>STUMP NECK ROAD</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>UNKNOWN</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNKNOWN</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>579-44-7249</b>		17. INFORMANT ADDRESS <b>HARRY KEITON, MARBURY, MD.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute alcoholism</b> 303- Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Ann M. Dixon</b>				TITLE (SPECIFY) <b>Assistant</b>				DATE SIGNED <b>1-5-79</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>				ADDRESS <b>111 Penn St.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>1-13-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ALEX. METH. CH.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>RISSON, CHARLES MD.</b>					
24. FUNERAL DIRECTOR NAME <b>Leon Thornton F. Home</b>				ADDRESS <b>R.R. 1 - BOHNS POMONKEY, MD.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 17 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Patricia McCurdy</b>			

MEDICAL CERTIFICATION

10-01693

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 79-01694	
1. DECEASED NAME (TYPE OR PRINT) <b>RAYMOND EARL SHENEMAN</b> <i>Raymond Earl Sheneman</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>Jan 22 79</i>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 1 1904</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ohio</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS.	
10. CITY OR TOWN OF DEATH <b>LaPlata</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Physicians Memorial Hospital</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Charles</b> MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Painter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Painting</b>		13a. STREET ADDRESS <b>Rt. 1, Box 380-A.</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Charles</b>		13c. CITY OR TOWN <b>Waldorf</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Allen Sheneman</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emma Conkle</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>	
16b. SOCIAL SECURITY NO. <b>214-03-0657</b>		17. INFORMANT <b>Dorothy M. Sheneman</b>		ADDRESS <b>Rt. 1, Box 380A.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardio-pulmonary failure</b> 4389 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION <b>1977</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Carcinoma (urinary bladder)</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>12/24</b> , 19 <b>78</b> , to <b>1/10</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>Jan 10</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Mohammed HAZI</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>1/22/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>M. HAZI</b>		22e. ADDRESS <b>Charles Prof. Bldg Waldorf</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1-25-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cem.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Colmar Manor, Pr. Geo. Md</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Huntt Funeral Home, Waldorf, Maryland</b>			
25a. DATE REC'D. BY REGISTRAR <b>JAN 26 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Rickie McCreedy</b>			

BP



79-01695

REG. NO.

FOR 1 - STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79-01695					
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lorendia Naomi Svenson.						2a. DATE OF DEATH MONTH DAY YEAR Jan 7 79				2b. HOUR 11:55 P.M.	
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 27, 1922		6. AGE (IN YEARS LAST BIRTHDAY) 56		IF UNDER 1 YEAR MONTHS DAYS YRS.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Nebraska		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Charles MD					
10. CITY OR TOWN OF DEATH La Plata		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Mem. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. STATE Md.		13b. COUNTY Charles		13c. CITY OR TOWN Waldorf		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2119 Dennis Court			
14 FATHER'S NAME FIRST MIDDLE LAST Paul Brockman		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Koch									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 508-16-2814		17 INFORMANT ADDRESS Paul A. Svenson same as # 13							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1749 Respiratory Collapse - DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Carcinoma - DUE TO, OR AS A CONSEQUENCE OF (c) Adenocarcinoma Breast - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3m	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 7 Jan 79, to 7 Jan 79, that (I) (we) last saw the deceased alive on 7 Jan 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Arthur O. Woody MD				DEGREE MD				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 8 Jan 79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARTHUR O. WOODY, MD				22e. ADDRESS Box 430 LaPlata, MD-20646.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-15-79		23c. NAME OF CEMETERY OR CREMATORY Lincoln Mem. Park				23d. LOCATION CITY OR TOWN COUNTY STATE Lincoln, Nebraska			
24. FUNERAL DIRECTOR NAME Hunt Funeral Home, Waldorf Md.						25a. DATE REC'D. BY REGISTRAR JAN 17 1979		25b. REGISTRAR'S SIGNATURE Lillian Brockman			

52-01892



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					79-01696 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Agnes V. Swann</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>January 31, 1979</b>			2b. HOUR <b>07:35</b>	
3 SEX <b>Female</b>		4 RACE <b>negro</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>January 28, 1920</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>59-60</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Charles MD.</b>			
10 CITY OR TOWN OF DEATH <b>La Plata</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Physicians Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>unemployed</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Baltimore</b>					13b. CITY OR TOWN <b>Charles</b>		13c. STREET ADDRESS <b>Pisgah Rd. 425 Pisgah, Md.</b>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>Carroll M. Swann</b>					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lula A. Swann</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>NOAE</b>		17 INFORMANT ADDRESS <b>Mary M. Gray Pisgah, Md. 20640</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Renal failure</b> 556- DUE TO, OR AS A CONSEQUENCE OF (b) <b>malabsorption syndrome, anemia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ulcerative colitis, Emaciation</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Feb. 1, 1979</b> to <b>Jan 31, 1979</b> , that (I) (we) last saw the deceased alive on <b>Jan 31, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Ignacio T. Garcia, M.D.</b>					DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>Feb. 1, 1979</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Ignacio T. Garcia M.D.</b>					22e. ADDRESS <b>La Plata, MD. 20646</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2-3-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Charles Cemetery, Glenmont, Charles, Md.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>Thomson's Funeral Home, Pikesville, Md.</b>					25a. DATE RECEIVED BY REGISTRAR <b>Feb 1, 1979</b>				
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>									

MEDICAL CERTIFICATION

19-01686

Approved: \_\_\_\_\_ Date: \_\_\_\_\_

Special Agent in Charge \_\_\_\_\_

Field Office \_\_\_\_\_

Re: \_\_\_\_\_

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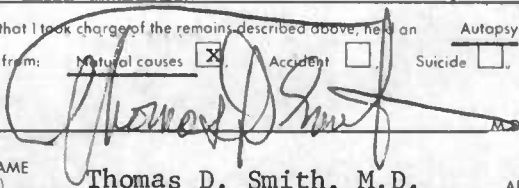
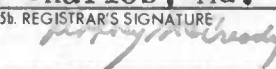
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										79-01697 REG. NO.	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) <b>Anne N/M/N Van Gelder</b>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>1</b> DAY <b>3</b> YEAR <b>19 79</b>		2b. HOUR <b>M</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>Aug.</b> DAY <b>28</b> YEAR <b>1949</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>29</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH <b>1</b> DAY <b>3</b> YEAR <b>19 79</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Scotland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>Scotland</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Charles County, MD.</b>		2d. HOUR <b>4:58</b>		2e. AM <b>A</b>	
10. CITY OR TOWN OF DEATH <b>La Plata</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Physician's Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Barmaid</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Rest.</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Charles</b>		13c. CITY OR TOWN <b>Waldorf</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>A 18 Idlewood Traylor Pk.</b>			
14. FATHER'S NAME FIRST <b>John</b> MIDDLE <b>Crighton</b> LAST <b>Waldorf</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Mary</b> MIDDLE <b>Mugrew</b> LAST <b>Mugrew</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>527-67-3623</b>		17. INFORMANT ADDRESS <b>8235 W. Marlette Glendale, Ariz.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ruptured saccular aneurysm of right middle cerebral artery</b> (b) <b>cerebral artery</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, and an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 		TITLE (SPECIFY) <b>Deputy Chief</b> MEDICAL EXAMINER						DATE SIGNED <b>1/4/79</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>		ADDRESS <b>111 Penn Street</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1-6-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Trinity Mem. Garden</b>		23d. LOCATION CITY OR TOWN <b>Waldorf, Charles, Md.</b> COUNTY STATE					
24. FUNERAL DIRECTOR NAME <b>The Hunt Funeral Home</b> ADDRESS <b>Waldorf, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 11 1979</b>		25b. REGISTRAR'S SIGNATURE 							

MEDICAL CERTIFICATION

70010-07

5M, 10M, 15M, 20M, 25M, 30M, 35M, 40M, 45M, 50M, 55M, 60M, 65M, 70M, 75M, 80M, 85M, 90M, 95M, 100M, 105M, 110M, 115M, 120M, 125M, 130M, 135M, 140M, 145M, 150M, 155M, 160M, 165M, 170M, 175M, 180M, 185M, 190M, 195M, 200M, 205M, 210M, 215M, 220M, 225M, 230M, 235M, 240M, 245M, 250M, 255M, 260M, 265M, 270M, 275M, 280M, 285M, 290M, 295M, 300M, 305M, 310M, 315M, 320M, 325M, 330M, 335M, 340M, 345M, 350M, 355M, 360M, 365M, 370M, 375M, 380M, 385M, 390M, 395M, 400M, 405M, 410M, 415M, 420M, 425M, 430M, 435M, 440M, 445M, 450M, 455M, 460M, 465M, 470M, 475M, 480M, 485M, 490M, 495M, 500M, 505M, 510M, 515M, 520M, 525M, 530M, 535M, 540M, 545M, 550M, 555M, 560M, 565M, 570M, 575M, 580M, 585M, 590M, 595M, 600M, 605M, 610M, 615M, 620M, 625M, 630M, 635M, 640M, 645M, 650M, 655M, 660M, 665M, 670M, 675M, 680M, 685M, 690M, 695M, 700M, 705M, 710M, 715M, 720M, 725M, 730M, 735M, 740M, 745M, 750M, 755M, 760M, 765M, 770M, 775M, 780M, 785M, 790M, 795M, 800M, 805M, 810M, 815M, 820M, 825M, 830M, 835M, 840M, 845M, 850M, 855M, 860M, 865M, 870M, 875M, 880M, 885M, 890M, 895M, 900M, 905M, 910M, 915M, 920M, 925M, 930M, 935M, 940M, 945M, 950M, 955M, 960M, 965M, 970M, 975M, 980M, 985M, 990M, 995M, 1000M, 1005M, 1010M, 1015M, 1020M, 1025M, 1030M, 1035M, 1040M, 1045M, 1050M, 1055M, 1060M, 1065M, 1070M, 1075M, 1080M, 1085M, 1090M, 1095M, 1100M, 1105M, 1110M, 1115M, 1120M, 1125M, 1130M, 1135M, 1140M, 1145M, 1150M, 1155M, 1160M, 1165M, 1170M, 1175M, 1180M, 1185M, 1190M, 1195M, 1200M, 1205M, 1210M, 1215M, 1220M, 1225M, 1230M, 1235M, 1240M, 1245M, 1250M, 1255M, 1260M, 1265M, 1270M, 1275M, 1280M, 1285M, 1290M, 1295M, 1300M, 1305M, 1310M, 1315M, 1320M, 1325M, 1330M, 1335M, 1340M, 1345M, 1350M, 1355M, 1360M, 1365M, 1370M, 1375M, 1380M, 1385M, 1390M, 1395M, 1400M, 1405M, 1410M, 1415M, 1420M, 1425M, 1430M, 1435M, 1440M, 1445M, 1450M, 1455M, 1460M, 1465M, 1470M, 1475M, 1480M, 1485M, 1490M, 1495M, 1500M, 1505M, 1510M, 1515M, 1520M, 1525M, 1530M, 1535M, 1540M, 1545M, 1550M, 1555M, 1560M, 1565M, 1570M, 1575M, 1580M, 1585M, 1590M, 1595M, 1600M, 1605M, 1610M, 1615M, 1620M, 1625M, 1630M, 1635M, 1640M, 1645M, 1650M, 1655M, 1660M, 1665M, 1670M, 1675M, 1680M, 1685M, 1690M, 1695M, 1700M, 1705M, 1710M, 1715M, 1720M, 1725M, 1730M, 1735M, 1740M, 1745M, 1750M, 1755M, 1760M, 1765M, 1770M, 1775M, 1780M, 1785M, 1790M, 1795M, 1800M, 1805M, 1810M, 1815M, 1820M, 1825M, 1830M, 1835M, 1840M, 1845M, 1850M, 1855M, 1860M, 1865M, 1870M, 1875M, 1880M, 1885M, 1890M, 1895M, 1900M, 1905M, 1910M, 1915M, 1920M, 1925M, 1930M, 1935M, 1940M, 1945M, 1950M, 1955M, 1960M, 1965M, 1970M, 1975M, 1980M, 1985M, 1990M, 1995M, 2000M, 2005M, 2010M, 2015M, 2020M, 2025M, 2030M, 2035M, 2040M, 2045M, 2050M, 2055M, 2060M, 2065M, 2070M, 2075M, 2080M, 2085M, 2090M, 2095M, 2100M, 2105M, 2110M, 2115M, 2120M, 2125M, 2130M, 2135M, 2140M, 2145M, 2150M, 2155M, 2160M, 2165M, 2170M, 2175M, 2180M, 2185M, 2190M, 2195M, 2200M, 2205M, 2210M, 2215M, 2220M, 2225M, 2230M, 2235M, 2240M, 2245M, 2250M, 2255M, 2260M, 2265M, 2270M, 2275M, 2280M, 2285M, 2290M, 2295M, 2300M, 2305M, 2310M, 2315M, 2320M, 2325M, 2330M, 2335M, 2340M, 2345M, 2350M, 2355M, 2360M, 2365M, 2370M, 2375M, 2380M, 2385M, 2390M, 2395M, 2400M, 2405M, 2410M, 2415M, 2420M, 2425M, 2430M, 2435M, 2440M, 2445M, 2450M, 2455M, 2460M, 2465M, 2470M, 2475M, 2480M, 2485M, 2490M, 2495M, 2500M, 2505M, 2510M, 2515M, 2520M, 2525M, 2530M, 2535M, 2540M, 2545M, 2550M, 2555M, 2560M, 2565M, 2570M, 2575M, 2580M, 2585M, 2590M, 2595M, 2600M, 2605M, 2610M, 2615M, 2620M, 2625M, 2630M, 2635M, 2640M, 2645M, 2650M, 2655M, 2660M, 2665M, 2670M, 2675M, 2680M, 2685M, 2690M, 2695M, 2700M, 2705M, 2710M, 2715M, 2720M, 2725M, 2730M, 2735M, 2740M, 2745M, 2750M, 2755M, 2760M, 2765M, 2770M, 2775M, 2780M, 2785M, 2790M, 2795M, 2800M, 2805M, 2810M, 2815M, 2820M, 2825M, 2830M, 2835M, 2840M, 2845M, 2850M, 2855M, 2860M, 2865M, 2870M, 2875M, 2880M, 2885M, 2890M, 2895M, 2900M, 2905M, 2910M, 2915M, 2920M, 2925M, 2930M, 2935M, 2940M, 2945M, 2950M, 2955M, 2960M, 2965M, 2970M, 2975M, 2980M, 2985M, 2990M, 2995M, 3000M, 3005M, 3010M, 3015M, 3020M, 3025M, 3030M, 3035M, 3040M, 3045M, 3050M, 3055M, 3060M, 3065M, 3070M, 3075M, 3080M, 3

## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH79-01698  
REG. NO.1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <u>Agnes V. Yates</u>			2a. DATE OF DEATH MONTH <u>Jan.</u> DAY <u>23</u> YEAR <u>79</u>			2b. HOUR <u>4:50</u> P.M.				
3. SEX <u>FEMALE</u>		4. RACE <u>NEGRO</u>		5. DATE OF BIRTH MONTH <u>NOV.</u> DAY <u>27</u> YEAR <u>1892</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>86</u> YRS		7. IF UNDER 1 YEAR MONTHS <u>0</u> DAYS <u>0</u> HOURS <u>0</u> MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MARYLAND</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>CHARLES</u> MD.				
10. CITY OR TOWN OF DEATH <u>LAPLATA</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Charles Co. Nursing Home</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife</u>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <u>MARYLAND</u>			13b. COUNTY <u>CHARLES</u>		13c. CITY OR TOWN <u>BELAITON</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS	
14. FATHER'S NAME FIRST <u>UNKNOWN</u> MIDDLE <u>UNKNOWN</u> LAST <u>UNKNOWN</u>				15. MOTHER'S MAIDEN NAME FIRST <u>FEBIA</u> MIDDLE <u>UNKNOWN</u> LAST <u>THOMAS</u>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>			16b. SOCIAL SECURITY NO. <u>215-54-7455</u>		17. INFORMANT <u>LEWIS YATES</u>			ADDRESS <u>FAULKNER, MD.</u>		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>4409</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Disease</u> (c) <u>aging</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR <u>19</u> A.M. MONTH <u>19</u> DAY <u>19</u> P.M.			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>MARCH</u> 19 <u>77</u> to <u>JANUARY</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>JAN. 23</u> 19 <u>79</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Ghassan Y. Al-Jainabi</u> DEGREE <u>M.D.</u>						22c. DATE SIGNED <u>1/23/79</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>GHASSAN Y. ALJAINABI</u>						22e. ADDRESS <u>9131 Piscataway Rd Clinton Md 20715</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>			23b. DATE <u>1-27-79</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST. IGNATIUS</u>		23d. LOCATION CITY OR TOWN <u>CHAPEL POINT</u> COUNTY <u>CHARLES</u> STATE <u>MD.</u>			
24. FUNERAL DIRECTOR <u>LEON THORNTON</u> ADDRESS <u>R.R. 1-Box 115 THORNTON FUNERAL HOME POMONKEY, MD.</u>						25a. DATE REC'D. BY REGISTRAR <u>JAN 29 1979</u>		25b. REGISTRAR'S SIGNATURE <u>Anthony McCreedy</u>		

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980  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

80010-01